larynx. Had a long course of iodide of potassium with no result. Emaciation, debility, with want of rest. Can take food, but deglutition causes pain. No absolute aphonia. Laryngoscopic examination showed both vocal cords ulcerated away in nearly their entire length. Irregular, white papillomatous nodules were projecting into the centre of the larynx from the sides immediately below the glottis. The false cords and the mucous membrane above were very much inflamed and bulged out by a solid growth beneath, more marked on the right side than on the left. Arytenoid cartilages not swollen or abnormally red; posterior commissure not thickened. Epiglottis and parts above free from disease. No enlarged glands; larynx freely movable. A small piece of growth removed and proved to be "a cornifying epitheliama." The whole of the larynx was removed. The patient made a good recovery, and an artificial larynx was afterwards applied. However, about five months afterwards the growth returned and the glands became affected. Dr. Gardner draws attention to the following points in the operation of removal of the larynx: (1). The ease by which the blood can be kept out of the trachea by the rectangular tube made the full diameter of the normal larynx, and inserted immediately after the division of the trachea, thus lessening greatly the risk of septic pneumonia. (2). That "the hanging head" position is also of immense advantage. (3). That it is probable in the great majority of cases that Gussenbauer's original artificial larynx is the best, although the straight upper tube seems to have suited the late Dr. Foulis' case. —*Lancet*, May 7, 1887.

H. H. TAYLOR (London),

VI. Œsophagotomy for a Half Penny Which had Ulcerated into the Bronchus. Recovery. By Mr. BENNET MAY (Birmingham). The patient was a child, æt. $7^1/_2$ years; three and a half years before he had been seen to swallow a half-penny, and since then had suffered from œsophageal obstruction, progressive emaciation and chest symptoms. No attempt at removal had been made. On examination he was found reduced almost to a skeleton; weight, $25^1/_2$ pounds. Swallowing very imperfect, with regurgitation of the most of it, voice hoarse, breathing stridulous, impaired resonance and deficient

breath sounds all over right side of chest. With a sound some obstruction detected above manubrium sterni. After several trials a No. 3 gum catheter was passed into the stomach and liquid food administered. Next day the child withdrew it, but swallowing was temporarily improved. The passage of this catheter was repeated twice within the fortnight when it could no longer be passed, and an operation became necessary. Œsophagotomy was performed as low as possible in the neck, and the edges of the wound in the œsophagus one and a half inches in length were held aside by wires passed through them. The finger in the œsophagus then detected a coin lying obliquely to the right of that tube, covered and obscured by its coats, *i. e.*, outside of it. After a careful incision the coin was seized and withdrawn through the œsophagus, although with difficulty, owing to its being firmly embedded. When disturbed a rush of air through the second œsophageal wound revealed a fistulous opening into the bronchus. No sutures were used at all. As no tube could be passed by the mouth into the stomach, alimentation was at first entirely rectal. This proved insufficient, and on the fourth day three ounces of milk were allowed to be cautiously sucked down, but half was regurgitated through the wound in the neck, and a little passed into the bronchus. More was taken in the following days, but as more was regurgitated the wound was kept from healing. On the fourteenth day the boy learned how to swallow a soft rubber catheter, and being thus fed, his wound improved, and in six weeks from the operation was healed. He had then only gained one pound in weight. On the seventh week he had an alarming attack of obstruction, probably from fœcal accumulation due to impaired digestion. This yielded to abstinence and enemata, and he then improved much more rapidly and gained 11½ pounds in the next six weeks. From this time his progress was only interrupted once or twice by his ravenously biting large pieces of unchewed food and partly choking on them. No tube could be passed but he was easily able to swallow a 12 or 13 soft catheter, and no symptoms of obstruction could be detected. In his concluding remarks, Dr. May points out that "this case is quite unique in the length of time intervening between the impaction of the foreign body and its successful

extraction, and also in the situation from which it was removed."—*Brit. Med. Jour.*, May 21, 1887.

CHAS. W. CATHCART (Edinburgh).

GENITO-URINARY ORGANS.

I. Manipulation Without Incision as Possible Treatment in Certain Cases of Stone in the Kidney. W. H. BENNET, F. R. C. S. The patient had for some time been suffering from symptoms of stone in the left kidney. As she was very thin and the kidney could be easily felt through the abdominal walls, she was placed under the influence of an anæsthetic and the kidney freely manipulated. When she recovered from the chloroform she complained of a little aching, but was able to walk home. Two days later she reappeared, and it appeared that on reaching home after the manipulation she was seized with an attack of renal colic which lasted some hours, after which she got complete relief.

Though so far only this one case is recorded, it is suggested that the plan is worthy of trial in certain cases.—*Lancet*, 1887, May 21, p. 1,026.

II. Removal by Abdominal Section of a Large Sarcoma of the Kidney, Which had Undergone Extensive Cystic Degeneration. Recovery from the Operation. Rapid Recurrence of the Disease. By C. T. CULLINGWORTH, M. D. The patient in question was supposed to be the subject of an ovarian cystoma. After admission, and even on reviewing the symptoms and signs carefully after operation, it was difficult to see what other conclusion could have been come to.

As soon as the abdomen was opened, it became clear that the tumor was situated behind the peritoneum, and on further examination that it was renal. The pedicle was treated in the same way as an ovarian pedicle, and the edges of the peritoneum were brought together and placed in apposition. All went well for some days, but a month later there were signs of fluctuation posteriorly, and some pus with the sloughed pedicle escaped eventually from an incision that was made posteriorly. Complete healing then ensued. The tumor